Washington Comprehensive Cancer Control
PARTNERSHIP
Working together to reduce cancer incidence, morbidity, and mortality in Washington State.

ORGANIZATION MEMBERSHIP APPLICATION

A. Organization Member Information

Name of Organization: _____

Mailing Address: _____ Physical Address: _____

_____ _____

Web Site Address: _____

Head of Organization (e.g., Director, CEO): _____
Printed name/credentials *Title*

Your signature indicates that your Organization agrees to comply with Membership requirements and bylaws.

_____
Signature *Date*

B. Official Organization Representative to WCCC Partnership

This person serves in the *official* organization representative capacity, as needed. In addition, this person participates in Partnership activities as an interested member from the organization.

Designated ***Official*** Representative: _____
Printed name/credentials *Title*

_____
Signature *Date*

Mailing Address: _____ Physical Address: _____

_____ _____

Phone: _____ Fax: _____ E-mail: _____

Administrative Assistant
Please indicate if there is an additional person through whom you would like us to correspond.

Assistant's Name: _____

Phone: _____ Fax: _____ E-mail: _____

Committee Selecction
Please select the committee(s) with which you would like to be involved.

- ❑ ***Primary Prevention Committee:*** Works to reduce or eliminate exposure to risk factors and promote protective factors.
- ❑ ***Secondary Prevention Committee:*** Works to reduce morbidity and mortality by identifying disease early and providing appropriate treatment.
- ❑ ***Medical Care Committee:*** Works to improve quality of and access to cancer treatment and care.
- ❑ ***Membership/Communications*** ❑ ***Policy and Legislation*** ❑ ***Evaluation***
- ❑ ***Colon Cancer Task Force*** ❑ ***Prostate Cancer Task Force***

C. Alternate Organization Representative to WCCC Partnership

This person takes the place of the *official* organization representative when needed. In addition, this person participates in Partnership activities as an interested member from the organization.

Designated ***Alternate*** Representative: _____
Printed name/credentials *Title*

_____
Signature *Date*

Mailing Address: _____ Physical Address: _____

_____ _____

Phone: _____ Fax: _____ E-mail: _____

Administrative Assistant
Please indicate if there is an additional person you through whom would like us to correspond.

Assistant's Name: _____

Phone: _____ Fax: _____ E-mail: _____

Committee Selecction
Please select the committee(s) with which you would like to be involved.

- ❑ ***Primary Prevention Committee:*** Works to reduce or eliminate exposure to risk factors and promote protective factors.
- ❑ ***Secondary Prevention Committee:*** Works to reduce morbidity and mortality by identifying disease early and providing appropriate treatment.
- ❑ ***Medical Care Committee:*** Works to improve quality of and access to cancer treatment and care.
- ❑ ***Membership/Communications*** ❑ ***Policy and Legislation*** ❑ ***Evaluation***
- ❑ ***Colorectal Cancer Task Force*** ❑ ***Prostate Cancer Task Force***

Please return completed application to:

Megan Roberts, Partnership Coordinator
Washington State Department of Health
Comprehensive Cancer Control Program
P.O. Box 47855
Olympia, WA 98504-7855

If you have questions regarding this application, please contact Megan Roberts at 360-236-3785 or megan.roberts@doh.wa.gov

Organization: _____

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D. Additional Interested Representative of the Organization

This person participates in Partnership activities as an interested member from the organization.

Name: _____
Printed name *Credentials* *Title*

Mailing Address: _____ Physical Address: _____

_____ _____

Phone: _____ Fax: _____ E-mail: _____

Administrative Assistant
Please indicate if there is an additional person through whom you would like us to correspond.

Assistant's Name: _____

Phone: _____ Fax: _____ E-mail: _____

Committee Selecction
Please select the committee(s) with which you would like to be involved.

- ❑ ***Primary Prevention***
- ❑ ***Secondary Prevention***
- ❑ ***Medical Care***
- ❑ ***Membership/Communications***
- ❑ ***Policy and Legislation***
- ❑ ***Evaluation***
- ❑ ***Colorectal Cancer Task Force***
- ❑ ***Prostate Cancer Task Force***

Name: _____
Printed name *Credentials* *Title*

Mailing Address: _____ Physical Address: _____

_____ _____

Phone: _____ Fax: _____ E-mail: _____

Administrative Assistant
Please indicate if there is an additional person through whom you would like us to correspond.

Assistant's Name: _____

Phone: _____ Fax: _____ E-mail: _____

Committee Selecction
Please select the committee(s) with which you would like to be involved.

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- ❑ ***Secondary Prevention***
- ❑ ***Medical Care***
- ❑ ***Membership/Communications***
- ❑ ***Policy and Legislation***
- ❑ ***Evaluation***
- ❑ ***Colorectal Cancer Task Force***
- ❑ ***Prostate Cancer Task Force***

Please make additional copies of this page as needed.

Submission of this form provides consent to capture this information in an electronic database for record keeping and communication purposes.

March 30, 2005